CaIPERS GROUP CONTINUATION COVERAGE

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT "COBRA"

PERS-HBD-85 (Rev 08/11)

PERS USE ONLY - DOCUMENT REFERENCE NUMBER

Public Employees' Retirement System

Office of Employer and Member Health Services

P.O. Box 942714

Sacramento, CA 94229-2714 888 CalPERS (or 888-225-7377)

TTY: For Speech & Hearing Impaired - (916) 795-3240 FAX (916) 795 -1313

PART A: ORIGINAL QUALIFYING EVENT AND DATES 1. Type of 2. QUALIFYING EVENT 3. EVENT DATE 4. COBRA ENROLLMENT PERIOR Action EMPLOYMENT SEPARATION TIMEBASE REDUCTION EMPLOYMENT SEPARATION 611 FROM 611	INSTRUCTIO	NS FOR COMPL	ETING THIS FO	RM ARE ON T	HE REV	ERS	E SIDE.	. PLEA	SE TY	PE							
EMPLOYMENT SEPARATION/TIMEBASE REDUCTION FROM 01 DIVORCELEGAL SEPARATION DIVORCELEGAL SEPARATION CHANGE DEATH OF AN EMPLOYEE/RETIREE DEATH OF AN EMPLOYEE/RETIREE DEPENDENT DEPENDENT CONTINUATION - ORIGINAL ENROLLEE ELIGIBLE FOR MEDICARE TO PART B: ENROLLEE INFORMATION S. COBRA ENROLLEE (MAY BE DIFFERENT THAN SUBSCRIBER) S. SUBSCRIBER (EMPLOYEE/RETIREE) SOCIAL SECURITY NUMBER SOCIAL SECURITY NUMBER NAME NAME ADDRESS NAME NAME NAME NAME NAME NAME NAME ADDRESS DEPENDENT INFORMATION DEPENDENT INFORMATION DAY PHONE SEX MALE FEMALE FEM	PART A: (ORIGINAL QU	IALIFYING E	/ENT AND I	DATE	S						MIII					
DIVORCE/LECAL SEPARATION	1. Type of	2. QUALIFYING EVENT							3. EVENT DATE		4. COBRA ENROLL				ENT	PERIO	
CHANGE CHILD CEASES TO BE A DEPENDENT DEATH OF AN EMPLOYEE/RETIREE DEPENDENT CONTINUATION - ORIGINAL ENROLLEE ELIGIBLE FOR MEDICARE TO PART B: ENROLLEE INFORMATION S. COBRA ENROLLEE (MAY BE DIFFERENT THAN SUBSCRIBER) G. SUBSCRIBER (EMPLOYEE/RETIREE) SOCIAL SECURITY NUMBER NAME SEX MALE FEMALE NAME		☐ EMPLOYMENT SEPARATION/TIMEBASE REDUC								r i				1			
DEATH OF AN EMPLOYEE/RETIREE DEPENDENT CONTINUATION - ORIGINAL ENROLLEE ELIGIBLE FOR MEDICARE DEPENDENT CONTINUATION - ORIGINAL ENROLLEE ELIGIBLE FOR MEDICARE	■ NEW										FRO	M	2	()1		
PART B: ENROLLEE INFORMATION 5. COBRA ENROLLEE (MAY BE DIFFERENT THAN SUBSCRIBER) 6. SUBSCRIBER (EMPLOYEE/RETIREE) SOCIAL SECURITY NUMBER NAME ADDRESS CITY, STATE, ZIP PART D: DEPENDENT INFORMATION DAY PHONE () MARRIED YES NO C C TO BE ENROLLED BIRTHDATE SEX MALE FEMALE FEMALE PART C: CARRIER INFORMATION 7. NAME AND ADDRESS OF HEALTH PLAN PLAN CODE: PREMIUM: \$ SSN FINAME OF PRIOR HEALTH PLAN 11. PERMITTING EVENT CODE PART E: ENROLLMENT CHANGES 9. NAME OF PRIOR HEALTH PLAN 11. PERMITTING 10. PRIOR PLAN CODE PART F: SIGNATURE OF ENROLLEE 14. LAGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAXE FUTURE PAYMENTS IN A ITMLEY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAXE FUTURE PAYMENTS IN A ITMLEY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT I THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY NOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNATURE 16. HEALTH BENEFITS OFFICER'S SIGNATURE AGENCY NAME AGENCY NAME AGENCY NAME 16. HEALTH BENEFITS OFFICER'S SIGNATURE	CHANGE	CHANCE															
PART B: ENROLLEE INFORMATION 5. COBRA ENROLLEE (MAY BE DIFFERENT THAN SUBSCRIBER) 6. SUBSCRIBER (EMPLOYEE/RETIREE) SOCIAL SECURITY NUMBER	Попиног	D DEATH OF AN EMPLOTEE/KETIKEE					=:										
5. COBRA ENROLLEE (MAY BE DIFFERENT THAN SUBSCRIBER) 5. COLAL SECURITY NUMBER		☐ DEPENDEN	CONTINUATIO	N - ORIGINAL	ENRO	LLEE	ELIGIB	LE FOR	MED	ICARE	то						
SOCIAL SECURITY NUMBER — SOCIAL SECURITY NUMBER — NAME ADDRESS CITY, STATE, ZIP PART D: DEPENDENT INFORMATION DAY PHONE MARRIED YES NO O O O O O O O O	PART B:	ENROLLEE IN	FORMATION	l													
NAME ADDRESS CITY, STATE, ZIP PART D: DEPENDENT INFORMATION DAY PHONE MARRIED YES NO TO BE ENROLLED SEX MALE FEMALE FEMALE FEMALE FEMALE FEMALE FERSON (FIRST) (MI) (LAST) MO DAY YR SELF PART C: CARRIER INFORMATION 7. NAME AND ADDRESS OF HEALTH PLAN FERSON FIRST) FEMALE FEM	5. COBRA ENROLLEE (MAY BE DIFFERENT THAN SUBSCRIBER)						UBSCR	RIBER (E	MPLC	YEE/R	ETIRE	EE)					
ADDRESS CITY, STATE, ZIP PART D: DEPENDENT INFORMATION A C UST OF ALL PERSONS (reducing self) DATE OF BIRTH FAMILY FAMILY RELATIONSHIP SELF PART C: CARRIER INFORMATION SEX MALE FEMALE PART C: CARRIER INFORMATION SEN FEMALE PART C: CARRIER INFORMATION N	SOCIAL SECURITY NUMBER — — —						SOCIAL SECURITY NUMBER — —										
CITY, STATE, ZIP PART D: DEPENDENT INFORMATION DAY PHONE () MARRIED YES NO TO BE ENROLLED. DATE OF BIRTH FAMILY RELATIONSHIP BIRTHDATE SEX MALE FEMALE OF (FIRST) (MI) (LAST) MO. DAY YR SELF PART C: CARRIER INFORMATION 7. NAME AND ADDRESS OF HEALTH PLAN PLAN CODE: PREMIUM: S SSN (FIRST) (MI) (LAST) PHONE: SSN PHONE: SSN PHONE: SSN PART E: ENROLLMENT CHANGES 9. NAME OF PRIOR HEALTH PLAN 11. PERMITTING EVENT DATE (FIRST) (MI) (LAST) SSN PART F: SIGNATURE OF ENROLLEE 14. I AGREE TO PAY THE PREMIUM POR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM ILI ARESULT IN AUTOMACH TE REMINISTRO OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. PART G: AGENCY INFORMATION 15. AGENCY NAME AGENCY CODE UNIT CODE	NAME					NAI	NAME										
CITY, STATE, ZIP PART D: DEPENDENT INFORMATION DAY PHONE () MARRIED YES NO TO BE ENROLLED. DATE OF BIRTH FAMILY RELATIONSHIP BIRTHDATE SEX MALE FEMALE OF (FIRST) (MI) (LAST) MO. DAY YR SELF PART C: CARRIER INFORMATION 7. NAME AND ADDRESS OF HEALTH PLAN PLAN CODE: PREMIUM: S SSN (FIRST) (MI) (LAST) PHONE: SSN PHONE: SSN PHONE: SSN PART E: ENROLLMENT CHANGES 9. NAME OF PRIOR HEALTH PLAN 11. PERMITTING EVENT DATE (FIRST) (MI) (LAST) SSN PART F: SIGNATURE OF ENROLLEE 14. I AGREE TO PAY THE PREMIUM POR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM ILI ARESULT IN AUTOMACH TE REMINISTRO OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. PART G: AGENCY INFORMATION 15. AGENCY NAME AGENCY CODE UNIT CODE	ADDRESS																
DAY PHONE () MARRIED YES NO C C C TO THE CARRIER INFORMATION DAY PHONE																	
DAY PHONE () MARRIED YES NO C C C TO BE ENROLLED: () TO BE ENROL	CITY, STATE, ZIP						PART D: DEPENDENT INFORMATION										
BIRTHDATE SEX MALE FEMALE OF FEMALE OF FEMALE NO FEMALE	DAY PHONE L						LIOT OF ALL I ENGOTIO (Including sell)						RTH	F	AMILY		
PART C: CARRIER INFORMATION 7. NAME AND ADDRESS OF HEALTH PLAN SSN (FIRST) (MI) (LAST) PLAN CODE: PREMIUM: \$ SSN (FIRST) (MI) (LAST) PHONE: SSN (FIRST) (MI) (LAST) PHONE: SSN (FIRST) (MI) (LAST) SSN PHONE: 10. PRIOR PLAN CODE 10. PRIOR PLAN CODE 10. PRIOR PLAN CODE 11. PERMITTING EVENT DATE 12. PERMITTING EVENT DATE 13. EFFECTIVE DATE OF CHANGE 14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLEMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED PART G: AGENCY INFORMATION 15. AGENCY NAME AGENCY CODE UNIT CODE	()		MARRIED [YES NO		то	TO BE EN	NROLLED:							RELA	TIONSHIP	
PART C: CARRIER INFORMATION 7. NAME AND ADDRESS OF HEALTH PLAN (FIRST)	BIRTHDATE		SEX MAI	E □ БЕМАІ	F	10.75	(FIRST)	(MI)	(L	AST)	MO.	DAY	YR	s	ELF	
7. NAME AND ADDRESS OF HEALTH PLAN SSN (FIRST) (MI) (LAST) PLAN CODE: PREMIUM: \$ SSN PHONE: (FIRST) (MI) (LAST) SSN (FIRST) (MI) (LAST) SSN PART E: ENROLLMENT CHANGES 9. NAME OF PRIOR HEALTH PLAN 11. PERMITTING EVENT DATE 12. PERMITTING EVENT DATE TO HANGE 10. PRIOR PLAN CODE 10. PRIOR PLAN CODE 11. PERMITTING EVENT DATE 12. PERMITTING EVENT DATE 13. EFFECTIVE DATE OF CHANGE 14. I AGREE TO PAY THE PREMIUM PROR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNATURE AGENCY NAME AGENCY NAME UNIT CODE	-		OEX INVE			N											
PLAN CODE: PREMIUM: SSN PHONE: PREMIUM: SSN PHONE: PREMIUM: SSN PART E: ENROLLMENT CHANGES 9. NAME OF PRIOR HEALTH PLAN 11. PERMITTING EVENT DATE 10. PRIOR PLAN CODE 10. PRIOR PLAN CODE 11. PERMITTING EVENT DATE 12. PERMITTING EVENT DATE 13. EFFECTIVE DATE OF CHANGE 14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED 16. HEALTH BENEFITS OFFICER'S SIGNATURE AGENCY NAME AGENCY NAME 16. HEALTH BENEFITS OFFICER'S SIGNATURE	PART C: CARRIER INFORMATION						SSN							la la			
PLAN CODE: PREMIUM: \$ SSN PHONE: (FIRST) (MI) (LAST) SSN PART E: ENROLLMENT CHANGES 9. NAME OF PRIOR HEALTH PLAN 11. PERMITTING EVENT DATE 12. PERMITTING EVENT 13. EFFECTIVE DATE OF CHANGE 10. PRIOR PLAN CODE 11. PERMITTING EVENT DATE 12. PERMITTING EVENT DATE 13. EFFECTIVE DATE OF CHANGE 14. LAGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED PART G: AGENCY INFORMATION 15. AGENCY NAME AGENCY CODE UNIT CODE	7. NAME AND ADDRESS OF HEALTH PLAN						(FIRST)	(MI)	(L	AST)	and a second	ON LOCK OF THE PARTY OF		SAMESICA	BADOSMI CONTROLOGICA	
PLAN CODE: PREMIUM: \$ SSN PHONE: SSN PART E: ENROLLMENT CHANGES 9. NAME OF PRIOR HEALTH PLAN			1				SSN										
PLAN CODE: PREMIUM: \$ SSN PHONE: SSN PART E: ENROLLMENT CHANGES 9. NAME OF PRIOR HEALTH PLAN							(EIDOT)										
PHONE: (FIRST) (MI) (LAST) SSN PART E: ENROLLMENT CHANGES 9. NAME OF PRIOR HEALTH PLAN 11. PERMITTING EVENT DATE 12. PERMITTING EVENT 13. EFFECTIVE DATE OF CHANGE 10. PRIOR PLAN CODE 10. PRIOR PLAN CODE 14. IAGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED PART G: AGENCY INFORMATION 15. AGENCY NAME 16. HEALTH BENEFITS OFFICER'S SIGNATURE AGENCY CODE UNIT CODE							(FIRST)	(MI)	(L	AST)				15		
PART E: ENROLLMENT CHANGES 9. NAME OF PRIOR HEALTH PLAN 11. PERMITTING EVENT DATE 12. PERMITTING EVENT 13. EFFECTIVE DATE OF CHANGE 10. PRIOR PLAN CODE 14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNATURE AGENCY NAME 16. HEALTH BENEFITS OFFICER'S SIGNATURE AGENCY CODE UNIT CODE	PLAN CODE	:	_ PREMIUM: \$				SSN		-								
PART E: ENROLLMENT CHANGES 9. NAME OF PRIOR HEALTH PLAN 11. PERMITTING EVENT DATE 12. PERMITTING EVENT TO DATE OF CHANGE 10. PRIOR PLAN CODE 10. PRIOR PLAN CODE 14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNATURE AGENCY NAME 16. HEALTH BENEFITS OFFICER'S SIGNATURE AGENCY CODE UNIT CODE	PHONE:						(FIRST)	(MI)	(L	AST)	SOUTHERNIES	SHIPPLY IDENSE	ever tree trees	asksunption		
PART E: ENROLLMENT CHANGES 9. NAME OF PRIOR HEALTH PLAN 11. PERMITTING EVENT DATE 12. PERMITTING EVENT CHANGE 10. PRIOR PLAN CODE 10. PRIOR PLAN CODE 11. PERMITTING EVENT DATE 12. PERMITTING EVENT CHANGE 13. EFFECTIVE DATE OF CHANGE 14. A GREET OF LOVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED PART G: AGENCY INFORMATION 16. HEALTH BENEFITS OFFICER'S SIGNATURE AGENCY CODE UNIT CODE	THORL.					_						Wilderstein	restrement to	LOS MERCOLEO	Medical Consultation of the Consultation of th	mineral services as services	
9. NAME OF PRIOR HEALTH PLAN 11. PERMITTING EVENT CODE 12. PERMITTING EVENT DATE 13. EFFECTIVE DATE OF CHANGE 10. PRIOR PLAN CODE 10. PRIOR PLAN CODE 14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED 16. HEALTH BENEFITS OFFICER'S SIGNATURE AGENCY NAME 16. HEALTH BENEFITS OFFICER'S SIGNATURE							SSN										
9. NAME OF PRIOR HEALTH PLAN 11. PERMITTING EVENT CODE 12. PERMITTING EVENT DATE 13. EFFECTIVE DATE OF CHANGE 10. PRIOR PLAN CODE 10. PRIOR PLAN CODE 14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED 16. HEALTH BENEFITS OFFICER'S SIGNATURE AGENCY NAME 16. HEALTH BENEFITS OFFICER'S SIGNATURE	DADTE	ENDOLLMEN	TCHANCES				A (+1 A)	-		48					62866		
EVENT CODE DATE CHANGE 10. PRIOR PLAN CODE 10. PRIOR PLAN CODE 14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED PART G: AGENCY INFORMATION 15. AGENCY NAME			A STATE OF THE PARTY OF THE PAR	44 DEDMIT	FINIO		10 00										
10. PRIOR PLAN CODE PART F: SIGNATURE OF ENROLLEE 14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED PART G: AGENCY INFORMATION 15. AGENCY NAME									NG E	/ENI					DAT	= OF	
PART F: SIGNATURE OF ENROLLEE 14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED PART G: AGENCY INFORMATION 15. AGENCY NAME					A(0.50									_			
PART F: SIGNATURE OF ENROLLEE 14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED PART G: AGENCY INFORMATION 15. AGENCY NAME	10. PRIOR P	LAN CODE		ľ	1			I		1			1	01	Ī		
14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED 15. AGENCY NAME			DE ENROLLE	F		-	AVEGAN							01			
AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED 15. AGENCY NAME					- DIDE		TO T.										
FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED PART G: AGENCY INFORMATION 15. AGENCY NAME																HATI	
ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED PART G: AGENCY INFORMATION 15. AGENCY NAME																THE	
SIGNATURE OF COBRA ENROLLEE (SEE ATTACHMENT FOR PRIVACY INFORMATION) DATE SIGNED PART G: AGENCY INFORMATION 15. AGENCY NAME							Secretary Interest		FY TH	AT TH	E INFO	DRMA	NOITA	PRO	VIDE	DBY	
PART G: AGENCY INFORMATION 15. AGENCY NAME	IVIE IS II	RUE AND CORK	ECT TO THE BE	STOP WIT KING	JVVLED	GE P	IND ABI	LIIT.									
PART G: AGENCY INFORMATION 15. AGENCY NAME				8													
15. AGENCY NAME 16. HEALTH BENEFITS OFFICER'S SIGNATURE AGENCY CODE UNIT CODE	SIGNATUR	E OF COBRA ENROLI	EE (SEE ATTACHME	NT FOR PRIVACY I	NFORMA	TION)				DATE	SIGNE	D					
AGENCY CODE UNIT CODE	PART G:	AGENCY INF	ORMATION														
	15. AGENCY NAME						16.	HEALTI	H BEN	EFITS	OFFIC	ER'S	SIGN	ATU	RE		
	AGENCY CODE UNIT CODE																

PRIVACY INFORMATION

Submission of the requested information is mandatory. The information requested is collected pursuant to the Government Code Sections (20000. et. seq.) and will be used for administration of the Board's duties under the California Public Employees' Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to another government agency (such as your employer) but only in strict accordance with current statutes regarding confidentiality. Failure to supply the information may result in the System being unable to perform its functions regarding your status.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS P.O. Box 942714, Sacramento, CA 94229-2714

INSTRUCTIONS FOR THE COMPLETION OF FORM HBD-85 (08/2011)

- Part A: 1. Type of Action. Check " NEW " if this is a new enrollment.

 Check "CHANGE" if family member is added, deleted, or any plan changes.
 - 2. Check applicable Original Qualifying Event and Dates.
 - 3. Provide original event date (separation, date of divorce, etc.).
 - 4. Original COBRA enrollment period.

Examples:

Separation from enrollment 4-15-2010 (Perm. Event) FROM 6-1-2010 TO 11-30-2011 Child attains age 26 on 6-15-2010 (Perm. Event) FROM 7-1-2010 TO 6-30-2013

- Part B: 5. Please provide all requested information.
 - 6. If the COBRA enrollee is a former dependent, the employee/retiree must be identified in Box 6.
- Part C: 7. Please identify the carrier. The COBRA enrollee must continue the same coverage which he or she had as an employee or as a dependent. Carrier changes are only allowed during the open enrollment period or if the enrollee moves into or out of a carrier's geographic service area. The carrier's name, address, phone number, plan code, and premium can be found in the annual "Health Plan Decision Guide" which is available in all employing agencies. The monthly premium may not exceed 102% of the group rate.
- Part D: 8. List all family members to be enrolled, including self.

Action Code: Use "A" to indicate which person is being added (or newly enrolled).

Use "D" to indicate if an individual is being deleted from an existing COBRA enrollment.

An Action Code is not required when changing carriers.

IMPORTANT: The addition or deletion of family members is regulated by time limits which are identical to those for active enrollees (subscribers).

- Part E: 9-10 Name and Plan Code of prior health plan if COBRA coverage is being changed.
 - 10-13 To be completed by the Health Benefits Officer.
- Part F: 14. Signature of COBRA enrollee and date signed.
- Part G: 15-16. To be completed by the (former) employing agency. For (former) dependents of retirees, CalPERS is the "employing agency".

IMPORTANT: It is the responsibility of the COBRA enrollee to report enrollment changes in a timely manner. Enrollment change requests must be submitted in accordance with existing regulations, laws, and the time limits applicable to the Public Employees' Medical and Hospital Care Act. All change requests are directed through the agency listed in Part G.